Washington State
Health Care Authority
Public Employees Benefits Board

Continuation of Coverage Election Notice

(36 month qualifying events)

READ NOW
You have 60 days after the postmark to elect to continue your PEBB health coverage.

HCA 50-802 (1/07)

PEBB contact information

You may obtain information about PEBB eligibility and COBRA and other continuation coverage from:

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Phone: 1-800-200-1004 or 360-412-4200

PEBB Web site: **www.pebb.hca.wa.gov**

You may find the Public Employees Benefits Board's existing laws in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of the Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's Web site at **slc.leg.wa.gov**.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

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Introduction

This notice contains important information about your right to continue your health care coverage in the Public Employees Benefits Board (PEBB) program.

"You" in this notice refers to each person who will lose PEBB coverage.

To elect continuation coverage, you must complete the appropriate enclosed election form and submit it to PEBB Benefit Services following the instructions in this notice. **If you do not elect to continue coverage, your PEBB coverage will end on the last day of the month you cease to be eligible under PEBB rules for coverage provided through your spouse's, qualified same-sex domestic partner's, or parent's group health coverage.**

The event that caused you to lose PEBB coverage is called a "qualifying event" and the date of that event is the date of your qualifying event. Each "qualified beneficiary" (each person who lost PEBB coverage due to the qualifying event) is entitled to elect continuation coverage to continue PEBB coverage for 36 months.

If you choose continuation coverage, it will begin the first day of the month following the date your employer-provided coverage ended. (Employer-provided coverage ends the last day of the month you no longer meet the definition of dependent in PEBB rules).

You do not have to send payment with your election form; however, we will not enroll you until we receive your first payment. Additional information about payment for continuation coverage is included later in this notice.

If you have questions about this notice or your rights to elect continuation coverage, please contact:

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Phone: 1-800-200-1004 or 360-412-4200

Important information about your continuation coverage rights

Continuation coverage provides the same medical and dental benefits available to other PEBB enrollees, including (for example) copayments, deductibles, and choice of health plans. Each qualified dependent who elects continuation coverage will have the same rights as PEBB enrollees, including open enrollment and special enrollment rights.

What is continuation coverage?

In this notice, "continuation coverage" refers to any of the following options you or your covered dependents may be eligible for to continue your PEBB coverage when it would otherwise end.

As a PEBB enrollee, you may be eligible for one or more of the following three continuation of coverage options:

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- PEBB Extension of Coverage
- PEBB-sponsored retiree coverage

All three options temporarily extend group health coverage if certain circumstances occur that would otherwise end your or your dependents' PEBB medical and dental coverage. COBRA continuation coverage is governed and administered by federal law and regulations. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA.

PEBB-sponsored retiree coverage is available only to individuals who meet the eligibility criteria in Washington Administrative Code (WAC) 182-12-171, or surviving dependents who meet eligibility criteria in WAC 182-12-250 or 182-12-265.

The HCA administers all three options.

A summary of the eligibility requirements for each continuation coverage follows:

- If you are enrolled in PEBB health coverage and are a qualified beneficiary under federal law, and if you have a qualifying event, you may be eligible to continue your PEBB coverage under **COBRA**. (See Appendix A.)
- If you are enrolled in PEBB health coverage and are not a qualified beneficiary under federal law, and have a qualifying event, you will not be eligible for COBRA but may be eligible to continue your medical and/or dental coverage under **PEBB Extension of Coverage**. People who are not qualified beneficiaries under COBRA law include qualified same-sex domestic partners, children of same-sex domestic partners, COBRA beneficiaries who become entitled to Medicare, and retirees and their dependents who cease to be eligible for PEBB-sponsored retiree coverage. (See Appendix A.)
- If you are a spouse, qualified same-sex domestic partner, or eligible child who will lose PEBB coverage due to the death of an eligible employee or PEBB retiree, you may be entitled to elect **PEBB-sponsored retiree coverage**. (See Appendix B.)
- If you are a spouse or eligible dependent of an emergency service employee killed in the line of duty as stated in WAC 182-12-250, you may be entitled to elect **PEBB-sponsored retiree coverage**. (See Appendix B.)

If you do not elect continuation coverage within 60 days of the postmark on this notice, you will lose your right to elect any continuation coverage options.

How to elect continuation coverage

To elect continuation coverage, you must complete the election form of the continuation coverage you choose, follow the procedures in this booklet, and mail or hand-deliver it to PEBB Benefit Services by the deadline specified in this document. **If you don't, you will lose your right to elect COBRA or other continuation coverage.**

Independent election rights

Each person who will lose PEBB coverage will have an independent right to elect COBRA or other continuation coverage. For example:

- You may elect continuation coverage for only one, several, or all eligible dependent children.
- Covered employees and spouses (if the spouse is a qualified dependent) may elect continuation coverage on behalf of all of the qualified dependent, and parents may elect continuation coverage on behalf of their eligible children.

Electing COBRA or PEBB Extension of Coverage

To elect COBRA or PEBB Extension of Coverage, you must complete the *COBRA Continuation or Extension of Coverage* form in Appendix A, and mail or hand-deliver it to PEBB Benefit Services. You have **60 days** after the date the *Continuation of Coverage Election Notice* is provided to you to elect COBRA or PEBB Extension of Coverage.

Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of elections, and will not preserve your COBRA rights.

If you are eligible for COBRA due to a qualifying event, you may elect medical and/or dental coverage from the plan(s) you were covered under on the day before the qualifying event. (For example, even if you had medical and dental coverage on the day before a qualifying event, you may elect COBRA for dental coverage only, medical coverage only, or both medical and dental.)

You may elect COBRA even if you have other group health coverage or are entitled to Medicare on or before the date you elect COBRA coverage. Your COBRA coverage will terminate automatically if you become entitled to Medicare after you enroll. However, you may continue your health coverage for the remainder of your COBRA period through PEBB Extension of Coverage.

If you elect COBRA or PEBB Extension of Coverage, your coverage will also end early if you enroll in other group health coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See "Termination of COBRA and other continuation coverage options before the end of the maximum coverage period" section starting on page 8.

Electing PEBB-sponsored retiree coverage as a surviving dependent

To elect PEBB-sponsored retiree coverage, you must complete the *PEBB-Sponsored Retiree Coverage Election Form* in Appendix B, and mail or

hand-deliver it to PEBB Benefit Services. You must apply for surviving dependent coverage within **60 days** after the date of the death of the employee or retiree.

Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of notifying us of your elections, and will not preserve your PEBB-sponsored retiree coverage rights.

If you are a spouse, qualified same-sex domestic partner, or eligible child who will lose PEBB coverage due to the death of an eligible PEBB employee or retiree, and you meet the requirements of WAC 182-12-265, you may elect to enroll in or defer PEBB retiree medical and dental coverage. (**Note:** Surviving spouses and dependent children of emergency service employees killed in the line of duty must meet the eligibility requirements in WAC 182-12-250.) You may **not** enroll in dental coverage only. Each qualified dependent (spouse, qualified same-sex domestic partner, and dependent child) who lost coverage due to the death of the employee or retiree has a separate right to elect PEBB-sponsored retiree coverage as a surviving dependent.

You may elect PEBB-sponsored retiree coverage even if they have other group health coverage or are entitled to Medicare. **If entitled to Medicare, you must enroll in Medicare Part A and Part B.**

More information about COBRA and other continuation coverage is available in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights.* This document is available online at www.pebb.hca.wa.gov and from PEBB Benefit Services.

Special considerations in deciding whether to elect COBRA

In considering whether to elect COBRA, you should take into account that choosing **not** to elect COBRA will affect your future rights under federal law. Here are some examples of how you could be affected:

- You could lose the right to avoid having preexisting-condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA may help you avoid such a gap.
- You lose the guaranteed right to purchase an individual health insurance policy that does not impose preexisting-condition exclusions if you do not get COBRA coverage for the maximum time available to you.
- You could lose the special enrollment rights granted to you by federal law. These rights include the right to request special enrollment in another group health plan you are eligible for (such as a plan sponsored by your spouse's employer) within 30 days after your PEBB coverage ends because of a qualifying event. If you enroll in COBRA for the maximum time available to you, you will also have the same special enrollment rights at the end of your COBRA coverage.

How long will COBRA or other continuation coverage last?

COBRA and PEBB Extension of Coverage provide temporary continuation of coverage. The periods described below are maximum coverage periods. Coverage can end before the end of the maximum coverage period for any of the reasons described under "Termination of COBRA and other continuation coverage options before the end of the maximum coverage period" beginning on page 8.

(1) When the qualifying event is death, divorce, legal separation, dissolution of a same-sex domestic partnership, or child's loss of dependent status

- When PEBB coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or when a dependent child is no longer eligible (as set forth in WAC 182-12-260), COBRA coverage can last up to 36 months.
- When PEBB coverage is lost due to the death of the employee, the covered employee's dissolution of a same-sex domestic partnership, or a dependent child of a qualified same-sex domestic partnership is no longer eligible (as set forth in WAC 182-12-260), PEBB Extension of Coverage can last up to 36 months.

(2) When the qualifying event is death of an employee or retiree

Surviving dependents who meet PEBB eligibility criteria (as set forth in WAC 182-12-250 and 182-12-265) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum period described below:

- The spouse or qualified same-sex domestic partner may continue coverage until death.
- The dependent children may continue coverage until they are no longer eligible (as set forth in WAC 182-12-260).

PEBB-sponsored retiree coverage provides coverage for eligible retirees, eligible dependents of retirees, and surviving dependents of employees, retirees, and emergency service personnel killed in the line of duty. The coverage periods described below are maximum coverage periods. Coverage can end before the end of the maximum coverage period for several reasons, as described in the "Termination of COBRA and other continuation coverage options before the end of the maximum coverage period on page 8.

(1) When the qualifying event is the death of an employee or retiree

Surviving dependents who meet PEBB eligibility (as set forth in WAC 182-12-265) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum periods described below:

- The spouse or qualified same-sex domestic partner may continue coverage until death.

- The dependent children may continue coverage until they are no longer eligible (as set forth in WAC 182-12-260).

(2) When the qualifying event is death of an emergency service employee killed in the line of duty

Surviving dependents who meet PEBB eligibility (as outlined in WAC 182-12-250) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum periods described below:

- The spouse may continue coverage until death.
- The dependent children may continue coverage until they are no longer eligible (as set forth in WAC 182-12-260).

Termination of COBRA and other continuation coverage options before the end of the maximum coverage period

(1) Automatic termination before the end of the maximum coverage period

COBRA and other continuation coverage options will automatically terminate before the end of the maximum period if:

(a) Any required premium is not paid in full on time.

(b) After electing COBRA or PEBB Extension of Coverage, a qualified dependent becomes covered under another group health plan (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied).

(c) A qualified beneficiary becomes entitled to Medicare benefits (Part A, Part B, or both) after electing COBRA; however, the qualified beneficiary will be eligible to continue coverage under the PEBB Extension of Coverage option until the end of his or her original COBRA period.

(d) The employer ceases to provide any group health plan for its employees (this is particularly important for people eligible through an employer group such as a political subdivision).

(e) Continuation coverage may also be terminated for any reason coverage would terminate for any other PEBB enrollee (such as fraud).

(2) Medicare entitlement or other coverage

You must notify PEBB Benefit Services in writing within **60 days** if, after electing continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health coverage (but only after any preexisting condition exclusions of that other plan have been exhausted or satisfied for your qualified dependent's preexisting condition).

Along with your written notice, please send a copy of the Medicare card. If the Social Security Administration denies enrollment in Medicare, send a copy of the denial letter.

If you enroll in other group health coverage, please send a copy of your enrollment letter.

How much does continuation coverage cost?

COBRA or PEBB Extension of Coverage

The amount you pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for similar coverage for a participant who is not receiving COBRA coverage. The monthly premiums for PEBB medical and dental plans are in Appendix A.

PEBB-sponsored retiree coverage

The monthly premiums for medical, dental, and retiree term life insurance are in Appendix B.

When and how do I make payments?

(1) How to make premium payments

You must pay all continuation coverage premiums by check, electronic funds transfer, or pension deduction. Make checks payable to the Washington State Treasurer. Your first payment and all monthly payments for continuation coverage must be mailed or hand-delivered to:

Mailing address	**Street address (for hand deliveries)**
Health Care Authority	Health Care Authority
PEBB Program	PEBB Program
P.O. Box 34270	676 Woodland Square Loop SE
Seattle, WA 98124-1270	Lacey, WA 98503

If you do not pay the full amount due within 45 days after the date you elect coverage, you will lose all rights to COBRA or other PEBB continuation coverage options. We will not make any exceptions to this on-time payment rule.

(2) When premium payments are considered made

We consider your payment made when it is received by PEBB Accounting at one of the addresses above. Payment will not be considered made if your check is returned due to insufficient funds or for any other reason.

(3) First payment for continuation coverage

If you elect to continue PEBB coverage, you do not have to send payment with the PEBB election form. However, you must make your first payment for continuation coverage no later than **45 days** after the date you elect coverage. This is the date your PEBB election form is received by PEBB.

Your first payment must cover the cost of continuation coverage from the time your PEBB coverage would have otherwise terminated up through the end of the month prior to when you make your first payment. For example: Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her first premium

payment covers the premiums for October and November and is due by December 30, the 45th day after the date of her COBRA election.

You must make sure the amount of your first payment is correct. You may contact PEBB Benefit Services to confirm the amount due.

We will not enroll you until you have elected to continue your PEBB coverage *and* made the first payment.

(4) Monthly payments for continuation coverage

After you make your first payment for continuation coverage, you make regularly monthly payments to continue your coverage.

The amount due each month is shown in this notice. Payment for continuation coverage is due on the 15th day of the month for that month's coverage. If you make a monthly payment on or before the 15th day of the current month, your PEBB coverage will continue for that month without any break.

You may not be billed for your continuation coverage premium. Depending on your payment method, we may send you periodic statements as a reminder of your responsibility to pay your premiums on time. You must pay your premiums on time, even if we do not send you a periodic statement. You will lose all rights to COBRA and other PEBB continuation coverage if you don't follow the payment instructions in this section.

If you fail to make a monthly payment before the end of the grace period, you will lose all rights to COBRA or other PEBB continuation coverage. No exceptions will be made for payments received after the end of this grace period.

(5) Grace periods for monthly premium payments

Although monthly payments are due on the 15th day of each month of continuous coverage, we will give you a 30-day grace period to make each monthly payment. Your PEBB continuation coverage will continue as long as payment for the current month is made before the end of the grace period.

Other individuals who may be qualified dependents

Children born to or placed for adoption with the covered employee during a period of continuation coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA or other continuation coverage is considered a qualified dependent if the employee has elected COBRA or other continuation coverage for himself or herself.

The child's COBRA coverage begins when the child is enrolled in PEBB coverage, whether through special enrollment or open enrollment. Coverage lasts for as long as the continuation coverage for the employee's other family members.

Notify PEBB Benefit Services of address changes

To protect your rights and the rights of your family, you should keep PEBB Benefit Services informed of address changes for all family members. You should also keep a copy of any notices you send to the HCA for your records.

To qualify to enroll in PEBB, the child must meet all other applicable PEBB eligibility requirements (for example, regarding age). See WAC 182-12-260(3), (4), and (5).

For more information

This notice does not fully describe your rights under COBRA or other continuation coverage. You can find more information in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* available on the PEBB Web site or from PEBB Benefit Services. Questions concerning your PEBB eligibility should also be addressed to PEBB Benefit Services.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other federal laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at **www.dol.gov/ebsa.** (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's Web site.)

Appendix A
(COBRA and PEBB Extension of Coverage)

Complete this *COBRA Continuation or Extension of Coverage* form if the qualifying event is one of the following:

Employee:

- Your employment ends for any reason other than gross misconduct.
- Your hours of employment were reduced.
- If you are appealing a dismissal, contact your payroll or benefits office to continue coverage under the Leave Without Pay (LWOP) option.

Spouse:

- Your spouse (the employee or retiree) dies.
- Your spouse's (the employee's) hours of employment are reduced other than his or her gross misconduct.
- Your spouse's (the employee's) employment ends for any reason other than gross misconduct.
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee or retiree) reduces or eliminates your Public Employees Benefits Board (PEBB) medical or dental coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Dependent child:

- Your parent (the employee or retiree) dies.
- Your parent's (the employee's) hours of employment are reduced.
- Your parent's (the employee's) employment ends for any reason other than his or her gross misconduct.
- You stop being eligible for PEBB coverage as a dependent child. (See WAC 182-12-260(3), (4), and (5).)

Retiree:

- You are are a retiree and your employer group terminated plan participation.
- You are a retiree and the Department of Retirement Systems has determined that you are no longer disabled, so your pension has stopped.

Same-sex domestic partner:

- Your same-sex domestic partner (the employee or retiree) dies.
- Your same-sex domestic partner's (the employee's) hours of employment are reduced.
- Your same-sex domestic partner's (the employee's) employment ends for any reason other than gross misconduct.
- You are the same-sex domestic partner of an employee or retiree, or the partner's covered dependent and the domestic partnership is dissolved.

COBRA Continuation or Extension of Coverage Election

Instructions

To elect COBRA or PEBB extension of coverage, complete this *COBRA Continuation or Extension of Coverage* form and mail or hand-deliver it to PEBB Benefit Services.

Mail to:
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Hand-deliver to:
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

You have **60 days** after the postmarked date of this *Continuation of Coverage Election Notice* to decide whether you want to elect COBRA.

Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of election, and will not preserve your COBRA rights.

If you do not submit a completed *COBRA Continuation or Extension of Coverage* form by this due date, you will lose your right to elect COBRA or PEBB Extension of Coverage.

Read the important information about your rights in the *Continuation of Coverage Election Notice* which includes this *COBRA Continuation or Extension of Coverage* form.

Public Employees Benefits Board (PEBB)

2007 COBRA Continuation or Extension of Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- Attach appropriate dependent certification forms if required (students age 20 through age 23, extended dependents, and dependents with disabilities.) Forms are available at **www.pebb.hca.wa.gov.**

Retiree Information ONLY	Retiree name	
	Retiree social security number	Date employer coverage ended (mm/dd/yyyy)

I/we elect COBRA continuation coverage as indicated below:

Section 1: SUBSCRIBER INFORMATION

Social security number	Sex ❑ M ❑ F	Last name	First name	Middle initial
Address				Apt./unit number
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )	Home phone number (including area code) ( )		

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code. ➡ Physician or clinic code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No Effective date_____

Section 2: SPOUSE OR SAME-SEX DOMESTIC PARTNER INFORMATION

List only eligible family members.

Social security number	Date of marriage or partnership criteria met (mm/dd/yyyy)	Physician or clinic code	Sex ❑ M ❑ F
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No Effective date_____

Section 3: FAMILY MEMBER INFORMATION *Use additional forms for more members. List only eligible family members.*

A

Relationship to subscriber	Social security number	Physician or clinic code	❑ Disabled? ❑ Student? *Check only if age 20 or older.*	Sex ❑ M ❑ F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No Effective date_____

B

Relationship to subscriber	Social security number	Physician or clinic code	❑ Disabled? ❑ Student? *Check only if age 20 or older.*	Sex ❑ M ❑ F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No Effective date_____

Section 4: MEDICAL PLAN SELECTION

(Check only one.)

- ❑ Community Health Plan Classic
- ❑ Group Health Classic
- ❑ Group Health Value
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Value
- ❑ Medicare Supplement Plan E, administered by Premera Blue Cross
- ❑ Medicare Supplement Plan J, administered by Premera Blue Cross
- ❑ Regence Classic*
- ❑ Secure Horizons Classic* (Medicare enrollees only)
- ❑ Secure Horizons Value* (Medicare enrollees only)
- ❑ Uniform Medical Plan

** These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.*

Section 5: DENTAL PLAN SELECTION

(Check only one.)

Preferred Provider Organization

❑ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name_____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 6: SIGNATURE (Required)

Insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Subscriber's signature _____ Date_____

Washington State Health Care Authority
Public Employees Benefits Board

Visit our Web site at www.pebb.hca.wa.gov

Please sign and date this form.

Return to:
Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

If payment enclosed, return to:
Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

For Agency Use Only ❑ 18-month (Terminated or reduction in hours) ❑ 29-month (Approved disability [SSI]) ❑ 36-month (Spouse/child: loss of dependent eligibility)

Washington State Health Care Authority
Public Employees Benefits Board

2007 PEBB COBRA and Extension of Coverage Monthly Rates

Effective January 1, 2007

Special Requirements

1. To qualify for the Medicare rate, you must be enrolled in both Part A and Part B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan, Kaiser Permanente Senior Advantage, or Secure Horizons must agree to complete and sign the *Medicare Advantage Plan Election Form* to enroll in one of these plans. For more information on these requirements, please contact your health plan's customer service department.

Medical Plans									
Subscribers not eligible for Medicare (or enrolled in Part A only):	Community Health Plan Classic	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Regence Classic	Secure Horizons Classic	Secure Horizons Value	Uniform Medical Plan
Subscriber Only	$ 480.75	$ 435.92	$ 390.81	$ 448.72	$ 409.12	$ 518.98	N/A	N/A	$ 401.66
Subscriber & Spouse	954.12	864.46	774.25	890.06	810.87	1,030.58	N/A	N/A	795.94
Subscriber & Child(ren)	835.78	757.33	678.39	779.73	710.43	902.68	N/A	N/A	697.36
Full Family	1,309.15	1,185.87	1,061.83	1,221.07	1,112.18	1,414.28	N/A	N/A	1,091.64
Subscribers enrolled in Part A & Part B of Medicare:									
Subscriber Only	$ 440.02	$ 335.70	$ 303.02	$ 312.80	$ 239.80	$ 520.16	$ 331.68	$ 254.58	$ 342.72
Subscriber & Spouse (1 eligible)	913.39	764.25	686.46	754.15	641.55	1,031.76	N/A	N/A	737.00
Subscriber & Spouse (2 eligible)	872.66	664.03	598.67	618.23	472.23	1,032.94	655.99	501.79	678.07
Subscriber & Child(ren) (1 eligible)	795.05	657.11	590.60	643.81	541.11	903.86	N/A	N/A	638.43
Subscriber & Child(ren) (2 eligible)	872.66	664.03	598.67	618.23	472.23	1,032.94	655.99	501.79	678.07
Full Family (1 eligible)	1,268.42	1,085.66	974.04	1,085.16	942.86	1,415.46	N/A	N/A	1,032.71
Full Family (2 eligible)	1,227.69	985.44	886.25	949.24	773.54	1,416.65	N/A	N/A	973.77
Full Family (3 eligible)	1,305.30	992.36	894.32	923.66	704.66	1,545.73	980.30	749.00	1,013.41

Medicare Supplement Plans						
	Premera Blue Cross					
	Plan E Retired	Plan E Disabled	Plan J Retired with Rx**	Plan J Disabled with Rx**	Plan J Retired without Rx	Plan J Disabled without Rx
Subscriber Only	$ 122.12	$ 207.61	$ 273.22	$ 464.47	$ 163.40	$ 277.77
Subscriber & Spouse (1 eligible)*	523.78	609.27	674.88	866.13	565.06	679.43
Subscriber & Spouse (2 eligible - 1 retired, 1 disabled)	329.73	329.73	737.69	737.69	441.17	441.17
Subscriber & Spouse (2 eligible)	244.24	415.22	546.44	928.94	326.80	555.54
Subscriber & Child(ren)*	425.21	510.70	576.31	767.56	466.49	580.86
Full Family (1 eligible)*	819.49	904.98	970.59	1,161.84	860.77	975.14
Full Family (2 eligible - 1 retired, 1 disabled)*	632.82	632.82	1040.78	1040.78	744.26	744.26
Full Family (2 eligible)*	547.33	718.31	849.53	1,232.03	629.89	858.63

* **If a Medicare supplement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP). The rates shown reflect the total rate due, including both the Medicare supplement and the UMP premiums.**

** **Plan J with Rx is no longer offered to new subscribers.**

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
Subscriber Only	$ 34.03	$ 40.49	$ 39.36
Subscriber & Spouse	68.05	80.99	78.72
Subscriber & Child(ren)	68.05	80.99	78.72
Full Family	102.08	121.48	118.09

Dental Plans Dental Only	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
Subscriber Only	$ 41.40	$ 47.87	$ 46.74
Subscriber & Spouse	75.43	88.36	86.10
Subscriber & Child(ren)	75.43	88.36	86.10
Full Family	109.46	128.86	125.46

Appendix B (PEBB-Sponsored Retiree Coverage)

Complete the *PEBB-Sponsored Retiree Coverage Election Form* if your PEBB coverage will end because of one of the following events:

- You are an employee who is retiring and eligible for PEBB-sponsored retiree coverage as set forth in WAC 182-12-171:
- You are a surviving spouse, qualified same-sex domestic partner, or dependent child of a deceased eligible employee or retiree, and eligible for PEBB-sponsored retiree coverage as set forth in WAC 182-12-265:
- You are the spouse or dependent child of an emergency service employee killed in the line of duty, and eligible for PEBB-sponsored retiree coverage as set forth in WAC 182-12-250.

Note: When you enroll in retiree coverage, the monthly premiums, medical plans available in your county, and benefits may change, depending on the plan you choose. For more information, refer to the *Retiree Enrollment Guide*. You can find this online at **www.pebb.hca.wa.gov** or request a copy by calling PEBB Benefit Services at 1-800-200-1004.

Locate your plan choice in the columns below and complete the appropriate form(s).

Form A	Forms A and C	Forms A and B
Community Health Plan Classic Group Health Classic Group Health Value Kaiser Permanente Classic Kaiser Permanente Value Regence Classic Uniform Medical Plan	Group Health Medicare Advantage Classic Group Health Medicare Advantage Value Kaiser Permanente Senior Advantage Classic Kaiser Permanente Senior Advantage Value Secure Horizons Classic Secure Horizons Value	Medicare Supplement Plan E* Medicare Supplement Plan J* **Administered by Premera Blue Cross*
Please note: If you're adding a **qualified same-sex domestic partner** to your coverage and completing Form B or C, same-sex domestic partners need to use the "spouse" sections.		

To enroll some eligible dependents, you may need to complete and attach other forms to the following retiree form. These forms are available online at **www.pebb.hca.wa.gov** or by calling PEBB Benefit Services.

To add this dependent:	Complete and attach this form:
Spouse or qualified same-sex domestic partner	*Spouse or Same-Sex Domestic Partner Certification*
Dependent age 20 through age 23	*Student Certification/Change*
Dependent with disabilities	*Certification of Dependents With Disabilities*
Dependent who is not your biological child, adopted child, or stepchild	*Extended Dependent Certification*

PEBB-Sponsored Retiree Coverage Election Form

Instructions

To elect PEBB-sponsored retiree coverage, complete the *PEBB-Sponsored Retiree Coverage Election Form* and return it to PEBB Benefit Services.

Mail to (if payment not enclosed):	**Mail to (if payment enclosed):**	**Hand-deliver to:**
HealthCare Authority PEBB Benefit Services P.O. Box 42684	Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695	Care Health Care Authority PEBB Benefit Services 676 Woodland Square Loop SE Lacey, WA 98503

To elect PEBB-sponsored retiree coverage, you must complete this *PEBB-Sponsored Retiree Coverage Election Form* in this appendix, and submit it to PEBB Benefit Services. You have **60 days** after the postmarked date of this *Continuation of Coverage Election Notice* to decide whether you want to elect PEBB-sponsored retiree coverage.

The *PEBB-Sponsored Retiree Coverage Election Form* must be completed and mailed or hand-delivered to PEBB Benefit Services at the address specified in this notice. **Oral communications (in person or by telephone) and electronic communications (e-mail or fax) are not acceptable methods of election and will not preserve your COBRA or PEBB-sponsored retiree coverage rights.**

If you do not submit a completed *COBRA Continuation Coverage Election* form or *PEBB-Sponsored Retiree Coverage Election Form* by this due date, you will lose your right to elect COBRA or other continuation coverage (including PEBB-sponsored retiree coverage).

Read the important information about your rights in the *Continuation of Coverage Election Notice,* which includes this *PEBB-Sponsored Retiree Coverage Election Form.*

Public Employees Benefits Board (PEBB)

PEBB-Sponsored Retiree Coverage Election Form

A

- **List all eligible family members you wish to enroll on this form.**
- **If deferring PEBB retiree coverage, complete sections 1 and 9.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if required (students age 20 through age 23, extended dependents, and dependents with disabilities). Forms are available at **www.pebb.hca.wa.gov**.
- If re-enrolling after deferment, you must attach proof of continuous medical coverage since your date of deferment.
- If you are a surviving spouse or dependent, provide the social security number of the deceased retiree in Section 1 SSN area.

Retiree or employee information ONLY	Retiree or employee name	Retirement system
	Retiree or employee social security number	Retirement date (mm/dd/yyyy)
For K-12 school district retirees only	School district	When does your current **school district** medical/dental **coverage end?** (mm/dd/yyyy)
Re-enrollment after deferment	Date other coverage ended (mm/dd/yyyy)	

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address	Apt./Unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)
		( )	( )

The medical plans marked with a "†" in Section 5 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for the code.**

Physician or clinic code

Election

Medical Coverage

❑ Enroll: ❑ Medical only ❑ Medical and dental

❑ Re-enrollment after deferment (You must provide proof of continuous coverage.) Date other coverage ended _____

❑ Defer (due to enrollment in employer coverage) **If deferring, see Section 9. Note: This defers coverage for all family members.**

❑ Defer (due to enrollment in a federal retiree program)

❑ Defer (due to Medicare–Medicaid with creditable coverage)

❑ Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB program.

Date you want coverage to end_____

Are you enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No If yes, effective date _____

Are you receiving Medicare disability? ❑ Yes ❑ No If yes, effective date _____
If yes, attach a copy of your Social Security Disability Award letter.

(continued on next page)

Section 2: Spouse or Same-Sex Domestic Partner

List only family members you wish to cover; family members cannot be enrolled in any other PEBB coverage.

Relationship to subscriber If adding a spouse or partner, please attach a completed *Spouse or Same-Sex Domestic Partner Certification* form.

❑ **Spouse:** date of marriage_____ ❑ **Same-sex domestic partner:** date criteria met _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	Physician or clinic code	

Notice of Qualifying Event (see below)

Medical Coverage
❑ Enroll
❑ Waive
❑ Terminate

Reason:
❑ Loss of student status ❑ Married ❑ Other (explain) _____
❑ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership
❑ Attained age that is no longer eligible for PEBB coverage
Date of qualifying event _____

Are you enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No If yes, effective date _____

Are you receiving Medicare disability? ❑ Yes ❑ No If yes, effective date _____
If yes, attach a copy of your Social Security Disability Award letter.

Section 3: Family Member Information (such as a child, grandchild, etc.) *Use additional forms for more members.*

1

Relationship	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	❑ Disabled? ❑ Student? *Check only if age 20 or older.*	Physician or clinic code

Address (if different from subscriber)	City	State	ZIP Code

Notice of Qualifying Event (see below)

Medical Coverage
❑ Enroll
❑ Waive
❑ Terminate

Reason:
❑ Loss of student status ❑ Married ❑ Other (explain) _____
❑ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership
❑ Attained age that is no longer eligible for PEBB coverage
Date of qualifying event _____

Are you enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No If yes, effective date _____

Are you receiving Medicare disability? ❑ Yes ❑ No If yes, effective date _____
If yes, attach a copy of your Social Security Disability Award letter.

(continued on next page)

Section 3: Family Member Information continued (such as a child, grandchild, etc.) *Use additional forms for more members.*

2

Relationship	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	❑ Disabled? ❑ Student? *Check only if age 20 or older.*	Physical or clinic code

Address (if different from subscriber)	City	State	ZIP Code

Notice of Qualifying Event (see below)

Medical Coverage ❑ Enroll ❑ Waive ❑ Terminate

Reason:
❑ Loss of student status ❑ Married ❑ Other (explain) _____
❑ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership
❑ Attained age that is no longer eligible for PEBB coverage
Date of qualifying event _____

Are you enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Are you enrolled in Part D of Medicare? ❑ Yes ❑ No If yes, effective date _____

Are you receiving Medicare disability? ❑ Yes ❑ No If yes, effective date _____
If yes, attach a copy of your Social Security Disability Award letter.

Section 4: Additions or Changes *Check all that apply.*

Retiree changed: ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan

Change in family status:

❑ **Adding a spouse or qualified same-sex domestic partner**
You **must** complete a *Spouse or Same-Sex Domestic Partner Certification* form, available from the Health Care Authority or online at **www.pebb.hca.wa.gov.**

❑ **Adding family member 1** (from Section 3) ❑ **Adding family member 2** (from Section 3)

Section 5: Medical Plan Selection *Check only one.*

❑ Community Health Plan Classic
❑ Group Health Classic
❑ Group Health Value
❑ Kaiser Permanente Classic
❑ Kaiser Permanente Value
❑ Medicare Supplement Plan E, administered by Premera Blue Cross*
❑ Medicare Supplement Plan J, administered by Premera Blue Cross*
❑ Regence Classic†
❑ Secure Horizons Classic† ‡
❑ Secure Horizons Value† ‡
❑ Uniform Medical Plan

*** You must fill out Form "B" for this Plan.**

† These plans require the physician or clinic code of your selected primary care provider. Contact your plan or go to the Provider Directory on our Web site for the code.

‡ These plans offer Medicare Advantage plans available only to Medicare enrollees where available. Complete and attach the *Medicare Advantage Plan Election* Form (form C).

Section 6: Dental Plan Selection *Check only one.*

Preferred Provider Organization

❑ Uniform Dental Plan (Group #3000)
(may receive services from any provider)

Note: Delta Dental is the parent company of Washington Dental Services (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name or clinic code _____
(must receive services from DeltaCare provider)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from Willamette Dental Group Provider)

❑ **Cancel Dental**
I understand
cover

(continued on next page)

Section 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB employee life insurance. Application for Retiree Term Life Insurance must be made at the time of retirement. The cost is $2.19 per month regardless of age.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. ❑ **Yes** ❑ **No**

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Coverage
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

Beneficiary_____ Beneficiary's SSN _____

Relationship to retiree _____ Beneficiary's date of birth _____

Beneficiary's address _____

_____

Section 8: Authorization for Enrollment and/or Premium

I authorize □

❑ Yes, deduct from my pension

❑ No, I will send my payment monthly (**Note:** You must make the first payment before you will be enrolled. Make checks payable to the Washington State Treasurer.)

Section 9: Signature *Required*

By submitting th□
I understand tha□
repayment of any □
fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority (HCA) to be ineligible for coverage.

If deferring coverage, I certify and understand the following provisions:

In order □ -
tinuous enrollment in employer-sponsored coverage to HCA during an annual open enrollment or within 60 days of the date the other coverage □

If deferrin□
in the future. To exercise re-enrollment, my surviving dependents or I must submit an enrollment form and proof of continuous enrollment in a federal-sponsored retiree medical plan to HCA during an annual open enrollment or within 60 days of the date the other coverage ends.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Washington State law may require disclosure of any information I submit as public record. The HCA's privacy notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Retiree signature _____ Date _____

Washington State Health Care Authority
Public Employees Benefits Board

Return form to:
Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

Be sure to sign and date this form.

Note: If you or your dependents are entitled to Medicare, you must be enrolled in **Medicare Parts A and B**. If you haven't done so already, please send a copy of the Medicare card(s) along with this form.

Visit our Web site at www.pebb.hca.wa.gov

Washington State Health Care Authority
Medicare Supplement Enrollment Form

B

PREMERA BLUE CROSS

SECTION 1 – APPLICANT INFORMATION

Your Social Security Number (must include) ☐☐☐-☐☐-☐☐☐☐		Spouse Social Security Number (if applying) ☐☐☐-☐☐-☐☐☐☐	
Your Last Name First Name Initial		Spouse Last Name First Name Initial	
Date of Birth (month/day/year) / /	☐ Male ☐ Female	Spouse Date of Birth (month/day/year) / /	☐ Male ☐ Female
Home Address (cannot be a P.O. box)	City State ZIP		
Billing Address (if different from above; not applicable to PEBB/K-12 retirees)	City State ZIP		
Mailing Address (if different from above addresses)	City State ZIP		
Phone Number ( )	Medicare Supplement Plan Desired ☐ Plan E ☐ Plan J		

The Health Care Authority sets the effective date for PEBB/K-12 retirees. For all other applicants, coverage starts on the first of the month after the application postmark date, if all information is completed and accurate, and you meet the eligibility requirements in Section 2 below. To request a later effective date (no more than 90 days from postmark date), state residents should write that date here: _____/01/_____.
If you are replacing a Medicare Advantage plan, you must request to delay the effective date until after the date your Medicare Advantage coverage ends. If you need help with this, please contact us at 1-800-817-3049.

SECTION 2 – ELIGIBILITY

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be either an eligible PEBB or K-12 retiree or the eligible spouse of such a retiree. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the time limits below. Please check the time limit that applies to you. Your spouse may enroll with you even if one of the events below does not apply to your spouse.

Check one; fill in the blank if needed.

- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date: _____
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ Within six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, only if you are transferring from another health plan with no lapse in coverage. Note: Existing PEBB and K-12 subscribers may change their coverage by applying for another program offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.

All Other Applicants

To be eligible, you must be a current Washington State resident. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the enrollment time limits below. Please check the time limit that applies to you. Your spouse may enroll with you even if one of the events below does not apply to your spouse.

If you are under 65, and your enrollment in Parts A and B of Medicare was more than six months from the date of this application, please provide a copy of your Award Notice from Social Security.

Check one; fill in the blank if needed.

- ☐ Within 60 days of establishing Washington State residency. Resident date:_____
- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date:_____
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ Within six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for persons who are not PEBB or K-12 retirees, only if you are transferring from another health plan with no lapse in coverage.

Additional Application Periods for All Eligible Applicants

1. You can also apply for the HCA Plan E or J if one of the two conditions below is true.
   a. You left the HCA Plan E or J to try a Medicare Advantage program (including Medicare HMO or PPO programs), PACE program, or Medicare Cost, Risk, or SELECT program for the first time. You may apply if you tried one program, more than one program of the same type, or more than one type of program. However, all four statements must be true:
      - You were covered under each program you tried for less than 12 months.
      - Each program (other than the most recent) was terminated voluntarily.
      - You switched programs within 63 days of the date the prior program terminated, with no other coverage in between.
      - The effective date of the last program you tried was less than 24 months after the effective date of the first program you tried.
   b. If you are applying for the HCA Plan E and J offered only to people who have Medicare by reason of age, you can also apply if, at age 65 and first becoming eligible for Medicare Part A, you enrolled in one or more PACE programs or Medicare Advantage programs (including Medicare HMO or PPO programs). All four statements in part "a." above must also be true.
2. You can also apply for the HCA Plan E coverage if one of the conditions below is true.
   a. You lose retiree group coverage.
   b. Your Medicare supplement coverage ended because the carrier became bankrupt or insolvent.
   c. You were covered under a Medicare SELECT, Advantage, Risk or Cost program, or a PACE program, and your coverage ended or will end for one of the following reasons:
      - The program was withdrawn in your area.
      - You moved away from the program's service area.
      - The carrier or agent materially misrepresented the program or materially breached its terms.

You must give us proof that you had and lost the coverage as described above. If you qualify for coverage under 1. or 2. above, you must apply no earlier than 60 days before your prior coverage is to end and no later than 63 days after that coverage ended. **Note: If you qualify under 1. above, you may apply only for the HCA Medicare supplement plan you had originally. Please complete the questions in Section 3.**

SECTION 3 – PRIOR COVERAGE

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. (See "Additional Application Periods for All Eligible Applicants" for details.)
Please answer all questions.

To the best of your knowledge,	**You**	**Spouse** (if applying)
1. a. Did you turn 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
b. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No

c. If yes, what is the effective date? (Please fill in on the card below.)

All applicants and their spouses, if applying, **must** fill in the boxes on the cards below with the information printed on their Medicare cards or include photocopy.
We cannot process your application without this information.

You

HEALTH INSURANCE
NAME OF BENEFICIARY
MEDICARE CLAIM NUMBER
IS ENTITLED TO — EFFECTIVE DATE
Part A Hospital Insurance / /
Part B Medical Insurance / /

Spouse (if applying)

HEALTH INSURANCE
NAME OF BENEFICIARY
MEDICARE CLAIM NUMBER
IS ENTITLED TO — EFFECTIVE DATE
Part A Hospital Insurance / /
Part B Medical Insurance / /

	You	**Spouse** (if applying)
2. Medicaid is a public aid program for people with low income. It is not the same as Medicare. Are you covered for medical assistance through the state Medicaid program? Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.	☐ Yes ☐ No	☐ Yes ☐ No
a. Will Medicaid pay your premiums for this Medicare supplement coverage?	☐ Yes ☐ No	☐ Yes ☐ No
b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? (**Important Note:** If you are receiving any kind of Medicaid assistance, you are not eligible to apply for this program.)	☐ Yes ☐ No	☐ Yes ☐ No
3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a PACE plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.	Start: / / End: / /	Start: / / End: / /

		You	Spouse (if applying)
	b. If you are still covered under the Medicare plan in 3.a., do you intend to replace your current coverage with this new Medicare supplement plan? (**Important Note:** If you do not intend to replace your other Medicare plan, you are not eligible to apply for this program. Your new Medicare supplement plan cannot take effect while a Medicare Advantage plan is still in force.)	☐ Yes ☐ No	☐ Yes ☐ No
	c. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
	d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
4.	a. Do you have another Medicare supplement policy or certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
	b. If so, with which company and what plan do you have?		
	Company ▶	_____	_____
	Plan (A, B, C etc.) ▶	_____	_____
	c. If so, do you intend to replace your current Medicare supplement policy with this coverage? (**Important Note:** If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this program.)	☐ Yes ☐ No	☐ Yes ☐ No
5.	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?	☐ Yes ☐ No	☐ Yes ☐ No
	a. If so, with which company and what kind of policy?		
	Company ▶	_____	_____
	Type of Policy ▶	_____	_____
	b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)	Start: ___/___/___ End: ___/___/___	Start: ___/___/___ End: ___/___/___

SECTION 4 – INFORMATION YOU NEED TO KNOW

A. Did you receive a copy of the Outline of Coverage? ☐ Yes ☐ No

B. Would you like to receive a copy of Medicare's "Choosing a Medigap Policy" guide? ☐ Yes ☐ No

C. You do not need more than one Medicare supplement contract.

D. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

E. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.

F. If, after purchasing this plan, you become entitled to Medicaid, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

G. If you are eligible for and have enrolled in a Medicare supplement plan by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement plan can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement plan under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

H. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (Q.M.B.) and a "Specified Low-Income Medicare Beneficiary" (S.L.M.B.).

SECTION 5 – BILLING

(STATE RESIDENTS ONLY -- DOES NOT APPLY TO PEBB OR K-12 RETIREES)

Please indicate your desired payment option (please do not send a payment at this time):

☐ Monthly Billing
☐ Monthly Automatic Funds Transfer (A.F.T.)

If you select the A.F.T. payment option you must sign and date the enclosed Automatic Funds Transfer Authorization form, and include a deposit slip or voided check from the account you will be using for payment.

SECTION 6 – SIGNATURE

I hereby apply for the Premera Blue Cross Group Medicare Supplement Plan, and agree to the terms of the contract offered. I understand that I must meet the applicable eligibility requirements and apply within the time limits that are shown on this form. ☐ **Yes** ☐ **No**. I understand that Premera Blue Cross may collect, use and disclose personal information about me as required or permitted by law to perform routine business functions, such as determining my eligibility for enrollment and benefits, paying claims and fulfilling other obligations stated in its contract with the Health Care Authority. If Premera Blue Cross discloses my personal information for any other reason, Premera Blue Cross will first remove any data that can be used to easily identify me or will get my signed authorization. I represent that the foregoing statements and answers are complete and true. I understand that all rights to payment of medical claims by Premera Blue Cross are void if any statement made by me herein is found to be false or incomplete. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

X _____ X _____

Applicant Signature Date Spouse Signature Date

CHECK LIST

To help us process your application faster, please take a moment to make sure that you have completed the following steps before you send your application.

1. You must be enrolled (or have proof of enrollment) in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
2. Fill in the sample Medicare card with the information on your own Medicare card or provide a copy of your Medicare card. We cannot process your application without your Medicare information.
3. You must answer all enrollment questions to the best of your knowledge.
4. Sign the application.
5. Include a copy of the certificate of coverage from prior insurer if needed to confirm prior coverage. If you are under 65, please include a copy of your Award Notice if needed (see Section 2).

Washington State Health Care Authority
Public Employees Benefits Board

Medicare Advantage Plan Election Form

C

Please fill in all information requested. Be sure to read the back of this form.

Retiree/Spouse Information

Social Security Number	Last Name (as appears on Medicare card) First Name Middle Initial	Home Phone ( )
Permanent Residential Address	❑ Male ❑ Female Date of Birth (Mo/Day/Yr) / /	(Mo/Day/Yr) ❑ Married / /
City State ZIP Code +4	County (Residence)	Medical/Dental Effective Date (Mo/Day/Yr)
Mailing Address (if different than above)	City State ZIP Code +4	County (Residence)
Relationship **SPOUSE**	Last Name First Name Middle Initial	Social Security Number / Date of Birth (Mo/Day/Yr) / /
Permanent Residential or Mailing Address (if different from above)	City State ZIP Code +4	

Medicare

Retiree

Retiree Name _____

Medicare Claim Number_____-_____-_____-_____

Is entitled to Hospital (Part A) Effective Date / / Medical (Part B) Effective Date / /

Spouse

Spouse Name _____

Medicare Claim Number_____-_____-_____-_____

Is entitled to Hospital (Part A) Effective Date / / Medical (Part B) Effective Date / /

PCP and Plan Choice

I wish to enroll in:

- ❑ Group Health Medicare Advantage Classic
- ❑ Group Health Medicare Advantage Value
- ❑ Kaiser Permanente Senior Advantage Classic
- ❑ Kaiser Permanente Senior Advantage Value
- ❑ Secure Horizons Classic
- ❑ Secure Horizons Value

I wish to cancel my current medical coverage: ❑ Yes ❑ No

I wish to enroll in:

- ❑ DeltaCare–Dentist or clinic code _____
- ❑ Regence BlueShield Columbia Dental Plan
  Clinic location _____
- ❑ Uniform Dental Plan

Retiree

Name of Contracting Primary Care Physician (PCP) (refer to Provider Directory) _____

Are you a current patient? ❑ Yes ❑ No

Spouse

Name of Contracting Primary Care Physician (refer to Provider Directory) _____

Are you a current patient? ❑ Yes ❑ No

Medical Information

1. **Do you currently have end-stage renal disease (kidney disease)?** Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, are you currently a member of PacifiCare of Oregon/ Washington? Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
2. **Do you have any health insurance other than Medicare?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, through which company?_____
   What type of policy?_____
   Do you intend to discontinue this policy?
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Note: Your answers to questions #3 and #4 below will **not** affect your eligibility to enroll in a Medicare Advantage plan.

3. **Do you live in an institution?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, name of institution _____
   Address _____
   Phone number _____
   Date of admission _____
4. **Are you currently receiving Medicaid?** Retiree: ❑ Yes ❑ No
   Spouse: ❑ Yes ❑ No If yes, Medicaid #: _____

Signature and Authorization

I authorize Department of Retirement Systems to deduct from my retirement allowance the amount required to pay for this coverage.
❑ Yes, deduct from my pension ❑ No, I will send my payment monthly

I certify that to the best o
coverage, I must maint
Boar

My signature below warrants that I have read and understand this Medicare Advantage Plan Election Form, including the Statement of Understanding on the 's Evidence of Coverage document for
your selected Medicare Advantage Evidence of Coverage document will be sent to you upon receipt of your enrollment by the plan.

_____ _____
Signature of Applicant (see Privacy Notice on back) Date Signature of Spouse Date

_____ _____
Signature of individual who assisted the applicant and/or spouse in completing this form Date Relationship to Applicant/Spouse

❑ If Durable Power of Attorney for Health Care (DPAHC) for applicant and/or spouse, indicate here and attach certificate or other written proof of legal guardianship.

Return to: Washington State Health Care Authority; P.O. Box 42684; Olympia, WA 98504-2684

HCA 51-576 (10/06)

STATEMENT OF UNDERSTANDING

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare Advantage contracting primary care physician (PCP) will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible).

I understand that I can be a member of only one Medicare Advantage coordinated care plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage coordinated care plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize the CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected prior to either permanently moving out of the service area or leaving the service area for more than twelve (12) months, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective with my date of retirement or January 1, if enrolling during the Public Employees Benefits Board (PEBB) annual open enrollment period. I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers.

Note: Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep it with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

Washington State law may require disclosure of any information you submit as a public record.
The Health Care Authority's Privacy Notice is available upon request
by calling 360-923-2822 or online at www.hca.wa.gov.

Washington State Health Care Authority
Public Employees Benefits Board

2007 PEBB Retiree Monthly Rates

Effective January 1, 2007

Special Requirements

1. To qualify for the Medicare rate, you must be enrolled in both Parts A and B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan, Kaiser Permanente Senior Advantage, or PacifiCare Secure Horizons must agree to complete and sign the *Medicare Advantage Plan Election Form* to enroll in one of these plans. For more information on these requirements, please contact your health plan's customer service department.

Medical Plans									
Subscribers not eligible for Medicare (or enrolled in Part A only):	Community Health Plan Classic	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Secure Horizons Classic	Secure Horizons Value	Regence Classic	Uniform Medical Plan
Subscriber Only	$ 471.32	$ 427.37	$ 383.15	$ 439.92	$ 401.10	N/A	N/A	$ 508.80	$ 393.78
Subscriber & Spouse	935.41	847.51	759.07	872.61	794.97	N/A	N/A	1,010.37	780.33
Subscriber & Child(ren)	819.39	742.48	665.09	764.44	696.50	N/A	N/A	884.98	683.69
Full Family	1,283.48	1,162.62	1,041.01	1,197.73	1,090.37	N/A	N/A	1,386.55	1,070.24
Subscribers enrolled in Parts A & B of Medicare:									
Subscriber Only	281.72	179.45	152.15	157.00	121.16	$175.51	128.41	360.29	186.33
Subscriber & Spouse (1 eligible)	745.81	599.59	528.07	589.69	515.03	N/A	N/A	861.86	572.88
Subscriber & Spouse (2 eligible)	556.21	351.67	297.07	306.77	235.09	343.79	249.59	713.35	365.43
Subscriber & Child(ren)	629.79	494.56	434.09	481.52	416.56	N/A	N/A	736.47	476.24
Subscriber & Child(ren) (2 eligible)	556.21	351.67	297.07	306.77	235.09	343.79	249.59	713.35	365.43
Full Family (1 eligible)	1,093.88	914.70	810.01	914.21	810.43	N/A	N/A	1,238.04	862.79
Full Family (2 eligible)	904.28	666.78	579.01	631.29	530.49	N/A	N/A	1,089.53	655.34
Full Family (3 eligible)	830.70	523.89	441.99	456.54	349.02	512.07	370.77	1,066.41	544.53

Medicare rates shown above have been reduced by the state-funded contribution of $149.67 per retiree per month.

Medicare Supplement Plans*				
	Premera Blue Cross			
	Plan E Retired	Plan E Disabled	Plan J Retired without Rx	Plan J Disabled without Rx
Subscriber Only	$ 68.29	$111.03	$ 88.93	$146.11
Subscriber & Spouse (1 eligible)**	454.84	497.58	475.48	532.66
Subscriber & Spouse (2 eligible - 1 retired, 1 disabled)	172.09	172.09	227.81	227.81
Subscriber & Spouse (2 eligible)	129.35	214.83	170.63	284.99
Subscriber & Child(ren) (1 eligible)**	358.20	400.94	378.84	436.02
Full Family (1 eligible)**	744.75	787.49	765.39	822.57
Full Family (2 eligible - 1 retired, 1 disabled)**	462.00	462.00	517.72	517.72
Full Family (2 eligible)**	419.26	504.74	460.54	574.90

Medicare rates shown above have been reduced by the state-funded contribution of $149.67 per retiree per month.

* **If a Medicare suppliement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP). The rates shown reflect the total rate due, including both the Medicare supplement and the UMP premiums.**

** **Plan J with Rx is no longer available to new subscribers.**

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
Subscriber Only	$ 33.36	$ 45.63	$ 38.59
Subscriber & Spouse	66.72	91.26	77.18
Subscriber & Child(ren)	66.72	91.26	77.18
Full Family	100.08	136.89	115.77

Retiree Life Insurance Self-Pay Rate - $2.19 per month

PEBB Life Insurance Conversion

When you terminate your employment or retire, you are entitled to convert your Public Employees Benefits Board (PEBB)-sponsored group life insurance policy to an individual whole life policy. You may do this *without providing proof of good health* when your coverage ends or is reduced under the group plan sponsored by the PEBB. You can also convert the group life coverage on your family members to individual whole life policies for each covered dependent. See your PEBB life insurance booklet for further details or call a customer service representative at ReliaStar Life Insurance Company (1-866-689-6990).

To apply for conversion of your group life insurance, fill out and mail the bottom part of this form to ReliaStar Life Insurance Company. **To protect your right of conversion, this form must be postmarked no later than 31 days (if you are terminating employment) or 60 days (if you are retiring) following the date your group coverage terminates.** When your application is received by ReliaStar, you should expect to receive the company's conversion application within 15 days.

Provided that you apply on time and pay your first premium, the converted policy will take effect either 31 days (for terminating employees) or 60 days (for retiring employees) after the date of termination of your group coverage. **You are covered by the group plan during the 31-day or 60-day conversion period, as long as premiums are paid.** You will be billed directly by ReliaStar Life Insurance Company for all premium payments retroactive to the date your group term life coverage ended. In addition, the company will provide all policy service you may require directly. The Health Care Authority will not be involved.

For terminating or retiring employees of PEBB-sponsored plans

I am interested in the conversion option described in my Group Insurance Certificate. Please furnish information and the necessary forms.

Employee's name	Social security number – –	Date of birth
Spouse's/same-sex domestic partner's name (Complete only if you are interested in converting his or her insurance.)		Date of birth

Phone number	State agency or institution	**Reason for Conversion**
Address	Apt./unit number	❑ Retiring Date_____
City, county, state, and ZIP Code		❑ Resigning Date_____
Note: If you are disabled and qualify for the waiver of premium benefit, check this box. ☐		❑ Other Date_____ If other, state reason _____

Date	Signature

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.pebb.hca.wa.gov.**

Washington State Health Care Authority
Public Employees Benefits Board

HCA 50-540 (11/04)

Please return to:
ReliaStar Life Insurance Company
P.O. Box 20 - Route 7325
Minneapolis, MN 55440-0020

HCA 50-802 (1/07)

Washington State
Health Care Authority
Public Employees Benefits Board
P.O. Box 42684
Olympia, WA 98504

Change Service Requested

READ NOW

You have 60 days after the postmark to elect to continue your PEBB health coverage.